Lesotho

The following provides a summary of specific guidelines from the country's national TB guidance strategy. Use the jump links in yellow to access details on case definitions, diagnostic methods, standard protocols, and DOTS recommendations. This summary can be downloaded or e-mailed to yourself or a colleague. The original country guidance document can also be found below the jump links for download.

Patient Population **Download summary page as PDF** **E-mail this page**
Suggest Updates

- Adults
- Children
- Pregnant and Breastfeeding Women

Adults

TB Screening Frequency for PLHIV:

HIV infected people (including children) should be screened for TB

Screening Recommendations during TB Treatment:

Serial sputum smear examinations should be performed at recommended intervals to verify the effectiveness of the treatment in killing the bacilli. Two sputum samples should be examined at the end of the second and fifth month and at the end of treatment for all sputum smear positive TB patients.

The two samples should be collected as 'early morning samples'.

Category 1 treatment

- 6-month treatment regimen: At time of diagnosis: sputum smear. At end of initial phase: sputum smear (end month 2). In continuation phase: sputum smear (end month 5). During last month of treatment: sputum smear (end month 6).

Category 2 regimen:

- 8-month treatment regimen: At time of diagnosis: sputum smear. At end of initial phase: sputum smear (end month 3). In continuation phase: sputum smear (end month 5). During last month of treatment: sputum smear (end month 8).

Case definition:

Smear-positive pulmonary tuberculosis:

A TB suspect is diagnosed as smear positive TB case if:

- Two sputum smears positive for AFB, or
- One sputum smear examination positive for acid-fast bacilli (AFB) with Chest X-ray abnormalities consistent with active TB and

- Laboratory confirmation of HIV infection or
- Strong clinical evidence of HIV infection.

Smear-negative pulmonary tuberculosis:

A TB suspect is diagnosed smear negative pulmonary TB if:

- At least two sputum specimens negative for AFB and
- Radiographic abnormalities consistent with active tuberculosis and
- Laboratory confirmation of HIV infection or
- Strong clinical evidence of HIV infection. and
- Decision by a clinician to treat with a full course of antituberculosis chemotherapy OR
- A patient with AFB smear-negative sputum which is culture-positive for Mycobacterium tuberculosis.

Diagnostic methods:

Sputum smear microscopy
Chest X-ray (CXR)

Standard TB Treatment Protocols:

Treatment of New tuberculosis cases: 2(HRZE/4(HR)

Recommended treatment regimen and dosages for Re-treatment (category 2)
Adult TB cases: 2HRZES/1HRZE/5HRE

DOTS Recommendations:

The public health priority of the NTP is to cure smear-positive cases, while preventing the emergence of drug resistance. Ensuring adherence to treatment through Directly Observed Treatment (DOT) is necessary to achieve this goal. Treatment support should be given to TB patients throughout the entire treatment period.

Children

TB Screening Frequency for PLHIV:

HIV infected people (including children) should be screened for TB

Screening Recommendations during TB Treatment:

Ideally, each child should be assessed by the NTP (or those designated by the NTP to provide treatment) at least at the following intervals: 2 weeks after treatment initiation, at the end of the intensive phase and every 2 months until treatment completion.

The assessment should include, as a minimum; symptom assessment, assessment of treatment adherence, enquiry about any adverse events and weight measurement. Medication dosages should be adjusted to account for any weight gain. Treatment adherence should be assessed by reviewing the treatment card. A follow-up sputum sample for smear microscopy at 2 months after treatment initiation should be obtained for any child who was smear-positive at diagnosis.

Follow-up Chest X-Rays are not routinely required in children, particularly as many children will have a slow radiological response to treatment. A child who is not responding to anti-TB treatment should be referred for further assessment and management. These children may have drug-resistant TB, an unusual complication of pulmonary TB, other causes of lung adherence.

Case definition:

a) Pulmonary TB, sputum smear-positive The criteria are:

- two initial sputum smear examinations positive for acid-fast bacilli; or
- one sputum smear examination positive for acid-fast bacilli plus CXR abnormalities consistent with active pulmonary TB, as determined by a clinician; or
- one sputum smear examination positive for acid-fast bacilli plus sputum culture positive for M. tuberculosis.

Adolescents, or children of any age with complicated intrathoracic disease, are more likely to have sputum smear-positive pulmonary TB.

b) Pulmonary TB, sputum smear-negative A case of pulmonary TB that does not meet the above definition for smear-positive pulmonary TB. Such cases include cases without smear results, which should be exceptional in adults but relatively more frequent in children. In keeping with good clinical and public health practice, diagnostic criteria for sputum smear-negative pulmonary TB should include:

- 2 initial sputum specimens negative for acid-fast bacilli; and
- radiological abnormalities consistent with active pulmonary TB; and
- no response to a course of broad-spectrum antibiotics; and
- decision by a clinician to treat with a full course of anti-TB chemotherapy.

Diagnostic methods:

The approach to diagnose TB in children follows the usual standard protocol in clinical practice. This includes:

- Careful history (including history of TB contact and symptoms consistent with TB)
- Clinical examination (including growth assessment)
- Tuberculin skin testing
- Bacteriological confirmation whenever possible
- Investigations relevant for suspected pulmonary TB and suspected extrapulmonary TB
- HIV testing (in high HIV prevalence areas)

Standard TB Treatment Protocols:

Category 1:

New smear-positive pulmonary TB
New smear-negative pulmonary TB with extensive parenchymal involvement.
Other forms of extrapulmonary TB other than TB meningitis 2RHZE/4RH.

Category 2:

A patient previously treated for TB as new case for more than one month in the past and now being treated for TB again. This includes treatment failure, relapse, and return after default cases (smear or culture positive). The recommended regimen is: 2HRZES/1HRZE/5HRE (Category II Regimen). The retreatment regimen has an initial phase of 3 months with 5 drugs (isoniazid, rifampicin, pyrazinamide, ethambutol and streptomycin), one month with 4 drugs ((isoniazid, rifampicin, pyrazinamide, ethambutol) and a continuation phase of 5 months with 3 drugs (isoniazid, rifampicin, ethambutol).

Pregnant and Breastfeeding Women

Standard TB Treatment Protocols:

The benefit of treating an active TB disease in a pregnant woman far outweighs and the risks that the drugs may pose to both the mother and the foetus. Most TB drugs are safe for use in pregnant women with the exception of streptomycin which is ototoxic to the foetus and should therefore not be used in pregnancy.

A woman who is breastfeeding and has TB should receive a full course of TB treatment. Timely and properly applied chemotherapy is the best way to prevent transmission of tubercle bacilli to the baby. All the TB drugs are compatible with breastfeeding and a woman taking them can safely continue to breastfeed her baby.
